Family: The Unique Component of Family Medicine

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For over a decade, authorities in the field of family medicine have been espousing the difference between general practice and family practice to be the latter's emphasis on the family as the unit receiving treatment.[1-5] These authorities leave little doubt that the "family" is the unique component in family medicine.

Surprisingly, however, little systematic effort has been made to place a major focus on the family as an integral part of the curricular content of family practice training programs. Indeed, a recent review of various behavioral science programs by the Society of Teachers of Family Medicine Task Force on Behavioral Science demonstrated that fewer than ten percent of those family practice residencies examined had any kind of systematic emphasis on the "family."[6] What is even more striking is the finding that not a single program had the "family" as its primary focus!

Instead, most programs have been content to describe and define this emphasis, but in actual practice focus more on training in the primary specialty areas of which family practice is comprised and/or the physician-patient relationship. The latter focus results in a greater emphasis on "whole person" medicine than on family medicine. It is as if programs have not made the shift from "whole person" medicine to family medicine or at least continue to stress the individual as the primary component of health care as opposed to the family as the primary component. As Geyman states: "Much emphasis has been placed upon care of the 'whole person' and the family, but actual practice still reflects a predominant focus on the individual rather than the family as the object of care."[2]

It is little wonder that some authorities in the field have observed an identity crisis among family practice residents.[7] That is, with family practice residents still learning and practicing "whole person" medicine, they are not much different from other primary care specialists, who also learn "whole person" medicine, even though it may be to a lesser degree. Indeed, it would seem that the lack of a systematic emphasis on the family as the treatment unit may be a primary contributory factor to such an identity crisis. This is reflected somewhat by the fact that recent programs which

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have attempted to overcome this identity crisis have instituted family practice rotations which stress such areas as the philosophy of family medicine, assignment of families to incoming residents, family systems theory, family communications theory, and life stages of the family.

One can note from the above that a systematic emphasis on the family is finally beginning to take hold in family medicine. Although one must be careful to heed Carmichael's caution not to "medicalize" the family,[8] an even greater focus on the family appears necessary. Aluise suggests a theoretical framework for organization of observations as one of the criteria for which family physicians are looking to the behavioral sciences.[9] Yet to date, with only a few notable exceptions, an integrated approach to such a theoretical framework, which would revolve around the family as the treatment unit, as well as the practice skills and the necessary attitudinal change, continue to be lacking.

One reason the "family" emphasis is lacking in most residency training programs is that few family practice staff, because of their own orientations and the theoretical frameworks of their respective disciplines, have been able to bring about the necessary attitudinal change themselves or to "reorient their practice toward the family as the patient."[2] Indeed, with few exceptions, the current disciplines involved in family practice have not successfully developed the appropriate attitude to teach family medicine in the truest sense. Even many former general practitioners who are now academicians in the family medicine field do not provide this reorientation, since their training was focused on episodic care rather than family-centered care. Geyman has expressed a similar situation: "All physicians have been conditioned by traditional medical education to focus predominantly on the sick patient, and the first priority is always the diagnosis and therapy of the individual's clinical problems. The pressures and time constraints of a busy practice may present further barriers to taking the broader view. But, in many instances, it is this next step—seeing the family as a unit as the patient—which is required for intervention to be effective."[2] At the other end of the continuum, even those programs which have "family therapists" as members of their staffs are finding it difficult to teach family medicine, since their approaches are too involved and require too much time to be practical for the family physician. Therefore, this reorientation is also necessary for the behavioral science practitioner, who needs to provide the teaching-demonstration role with the family as the unit of treatment and to provide more practical approaches of applying the behavioral sciences to family medicine.

How, then, does the field of family medicine develop the reorientation toward the family and an integrative set of ideas and practice skills? Geyman has proposed several "useful concepts and principles" to implement comprehensive family-centered care.[2] Additionally, other authorities in the field have identified the family life cycle with its developmental phases and "normative" crises as a theoretical structure for emphasizing the family within family practice, as well as a means of providing practical aspects of various behavioral science topics.[10,11] As such, it appears to be the natural foundation on which to broaden understanding and effectiveness and to develop a family focus. Knowledge can be organized and integrated through this framework and gained through behavioral science seminars, conferences, case presentations, hospital rounds, clinic consultations, and other aspects of the curriculum. Within these areas, there is emphasis on the family and its dynamics as the teaching unit of family medicine. Finally, learning experiences can be gained on a practical basis through such modalities as assignment of families to incoming residents, identification of families in treatment, audio/video taping programs, role playing exercises, demonstration interviews, completion of family data bases, family therapy, and dual treatment. Several family practice residencies have instituted the above within their programs but with insufficient focus on the total family system in actual practice. It is essential that a comprehensive family systems perspective be provided within the family medicine knowledge base and clinical experience.

Although the family is receiving a stronger emphasis in various family practice residency training programs, the importance of family-centered care is also being recognized. At this point in the evolutionary process of family medicine, it is necessary to integrate the theoretical framework with the practice skills. Therefore, if the discipline is to continue to grow and intervention is to be effective, family medicine needs to incorporate a dual

focus on the whole person and the family in order to enlarge perceptions and broaden understanding. In essence, the question of where the focus on the family should be in family medicine needs an answer, not only within the conceptual framework but also in day-to-day practice. Family medicine can provide a comprehensive approach and quality care to the family. As Bauman and Grace have stated: "There are many advantages which can be realized when the family physician develops an increased awareness of family dynamics and cares for the family as a unit."[5]

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